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Egyptian Regional Human Rights Authority
Report of Findings
09-110-9052
Chester Mental Health Center
April 27, 2010

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility, which is the most restrictive mental health center in the state, provides services for approximately 250 male residents. The specific allegations are as follows:

1. A Recipient at Chester Mental Health Center has been forced to take medication over his objection.
2. The recipient has been placed in restraints without a valid reason for their use.
3. The recipient was placed in seclusion without a valid reason for the seclusion.

Statutes

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5/2-107, 405 ILCS 5/2-107.1, 405 ILCS 5/2-108, 405 ILCS 5/2-109 and 405 ILCS 5/2-201).

Section 5/2-107 (a) states, "An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services."

Section 5/2-107.1 (4) states, "Psychotropic medication and electroconvulsive therapy may be administered to the recipient if and only if it has been determined by clear and convincing evidence that all of the following factors are present. In determining whether a person meeting the criteria specified in the following paragraphs, (A) through (G), the court may consider evidence of the person's history of serious violence, repeated past pattern of specific

behavior, actions related to the person's illness or past outcomes of various treatment options. (A) That the recipient has a serious mental illness or developmental disability. (B) That because of said mental illness or developmental disability, the recipient currently exhibits any one of the following: (i) deterioration of his or her ability to function, as compared to the recipient's ability to function prior to the current onset of symptoms of the mental illness or disability for which treatment is presently sought, (ii) suffering, or (iii) threatening behavior. (C) That the illness or disability has existed for a period marked by the continuing presence of the symptoms set forth in item (B) of this subdivision (4) or the repeated episodic occurrence of these symptoms. (D) That the benefits of the treatment outweigh the harm. (E) That the recipient lacks the capacity to make a reasoned decision about the treatment. (F) That other less restrictive services have been explored and found inappropriate. (G) If the petition seeks authorization for testing and other procedures, that such testing and procedures are essential for the safe and effective administration of the treatment."

Section 5/2-108 states, "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a recipient, nor is restraint to be used as a convenience for staff."

Section 5/2-109 states, "Seclusion may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others. In no event shall seclusion be utilized to punish or discipline a recipient, nor is seclusion to be used as a convenience for the staff."

Section 5/2-201 states, "Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designed under 'An Act in relation to the protection and advocacy of the rights or persons with developmental disabilities and amending the Acts therein named' approved September 20, 1985, if either is so designated; and (5) the recipient's substitute decision maker, if any. The professional shall be responsible for promptly recording such restriction or use of restraints or seclusion and the reason therefor in the recipient's record."

Investigation Information for Allegation 1:

Allegation 1: A recipient at Chester Mental Health Center has been forced to take medication over his objection. To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit, the Team spoke with the recipient whose rights were alleged to have been violated and a Representative (Representative) from the facility's Human Rights Committee. The recipient's clinical chart was reviewed with his written authorization.

I. Interviews:

A...Recipient:

The recipient informed the Team that he does not have a mental illness; therefore, he does not need to have any type of psycotropic medications administered. He stated that he informed facility medical staff that he doesn't want any 'mind controlling' medication; however, he is required to take the medications without his consent.

B...Representative:

When the Team spoke to the Representative concerning the allegation, the Representative stated that the facility abides by the Code's requirements, which allow for a recipient's refusal to take medications. However, if the Treatment Team and medical staff determined that medication was necessary for the recipient to refrain from self harm or harm to others, a petition for enforced medication(s) would be submitted to the court. The Representative provided the recipient's clinical chart for the Team's review information relevant to the allegation.

II: Clinical Chart Review:

A...Treatment Plan Reviews (TPRs):

According to a 03/30/09 TPR, the 42-year old was transferred to Chester Mental Health Center from a less restrictive mental health center on 12/12/08 with a legal status of Not Guilty by Reason of Insanity (NGRI). Documentation indicated that the recipient had refused psychotropic medications at the transferring facility since 10/21/08. The record indicated his past history of having a high potential for violence in an unmedicated state. According to the documentation, when the recipient is not taking psychotropic medication he decompensates, engages in physical and verbal aggression and displays inappropriate sexual behaviors. Documentation indicated that at the transferring facility the recipient assaulted a peer causing him bodily injury. While staff members were taking care of the injured peer he assaulted another peer causing injuries that required sutures.

The recipient's diagnoses were listed as follows: AXIS I: Schizophrenia, Paranoid Type; AXIS II: Antisocial Personality Disorder with Paranoid Traits; AXIS III: No diagnosis; AXIS IV: History of Mental Illness; Non-compliance with medication; Criminal History; History of Incarceration (Federal), Poor Insight and Judgement.

The recipient strengths were listed as follows: 1) Apparent lack of health problems; 2) Able to complete Activities of Daily Living;3) Highly functional; and 4) Cooperative with staff and peers at the time of the TPR.

His problems were listed as: 1) Physical aggression, as evidenced by his history of maladaptive behaviors, which included staff and peer assault at the transferring facility and a criminal charge of murder. 2) Non-compliance with medication, as evidenced by his history of

non-compliance with medication being a factor in his maladaptive behaviors of staff and peer assault at the transferring facility.

The TPR contained a goal for the recipient to be free of displaying aggressive behavior toward others by 12/20/09. An objective listed was for the recipient to take medication as prescribed. The recipient's psychiatrist documented that the recipient had been compliant and was no longer aggressive, but remained hostile and argumentative. A Registered Nurse (RN) documented that the recipient had been compliant with taking prescribed medications.

In the Extent To Which Benefitting From Treatment Section of the TPR, documentation indicated that the recipient had adjusted well to the routine of the facility. He had been compliant with module rules; had signed and verbalized a willingness to be compliant with medication orders; and appropriately socializes with staff members and peers on the module.

Documentation in the recipient's 04/28/09 TPR indicated that the recipient has been compliant with taking medication, but continued to believe that he doesn't need psychotropics, stating that he doesn't want his mind controlled. An RN recorded that the recipient had refused medication once during the monthly reporting period.

The Team did not observe any documentation in the recipient's clinical chart to indicate that the recipient had received any type of court-ordered medications. However, the record indicated that the recipient had provided consent to take the prescribed medications.

Summary of Allegation 1

According to the recipient whose rights were alleged to have been violated, he was required to take psychotropic medications that he did not want to take. The record indicated that based on past history, the recipient exhibited maladaptive behaviors when he was not taking psychotropic medication. However, documentation throughout the recipient's clinical chart indicated that the recipient had expressed that he did not have a mental illness that necessitated him taking the psychotropic medications; however, he consistently complied with their administration.

Conclusion of Allegation 1:

Based on the information obtained, the allegation that the recipient was forced to take psychotropic medication against his will is unsubstantiated. No recommendations are issued.

Allegation 2 and Allegation 3: The recipient has been placed in restraints and seclusion without a valid reason for their use. To investigate the allegation, the Team spoke with the recipient whose rights were alleged to have been violated and reviewed his clinical chart.

I: Interview with Recipient:

During a site visit to the facility, the Team spoke with the recipient about the allegation. He informed the Team that facility staff placed him in restraints on 04/17/09 for no apparent reason. The recipient denied having been aggressive toward others or exhibiting any self-harm behaviors. He stated that after the restraint episode he was placed on the red level, the lowest level in the facility's system procedure with limited access to areas and programs at the facility. However, at the time of the visit he had progressed to the yellow level, the mid level of the system, allowing greater access to enjoyable activities.

II: Clinical Chart Review:

A: TPR:

In a 04/28/09 TPR the recipient's Therapist documented that the recipient had several Behavior Data Reports for aggressive behaviors and had one restraint episode; however he was making an effort to be more compliant with unit rules and treatment expectations. A RN recorded that the recipient had been placed into seclusion on 04/19/09 and had to be moved into restraints.

B: Orders for Restraint Or Seclusion (Order):

According to an Order for seclusion on 4/19/09 at 9:15 AM, the recipient dropped a pill on the floor and stepped on it causing the pill to crush. When staff obtained another pill for the recipient to take, he began to yell, scream and make threats of violence toward staff. The recipient was counseled; however, he failed to calm himself and requested to go to seclusion. Documentation indicated that the recipient walked to the seclusion room without the need for a physical hold.

Criteria listed for the recipient to be released from the seclusion was listed as follows: He must become calm, cooperative and appropriate during reviews and no longer agitated, demanding and threatening for 1 hour. He was given medication to assist him with anxiety; however, he continued the aggressive, threatening behaviors. Documentation indicated that the recipient started banging on the door in the seclusion room, demanding to be placed in restraints at 5:30 PM on 04/19/09.

An Order for 4-point restraints was issued at 5:30 PM. Documentation indicated that previous interventions had failed and the recipient had demanded to be placed in restraints. The Order was issued for up to 4 hours. The release criteria was listed follows: 1) The recipient must be calm, quiet and talking rationally for 60 minutes; 2) He must be free of pulling on the restraints for 60 minutes; 3) He must be free of threatening and aggressive behaviors for 60 minutes.

C: Restraint/Seclusion Flowsheets (Flowsheets):

Documentation in the Flowsheets indicated that prior to restraint application, a body search was conducted and the room environment was determined to be appropriate. Staff determined that the restraints were properly applied; the recipient was wearing proper clothing; and he was properly placed in the restraints. He was informed of the reason for the restraint, the criteria for release, and was provided with a Restriction of Rights Notice.

Additional documentation indicated that the recipient was constantly observed and his behaviors/condition was recorded in 15-minute increments. A RN checked his circulation, released his limbs, checked his vital signs, offered fluids and toileting, and evaluated his physical status every hour. The recipient was not offered meals because the restraint episode did not continue during scheduled meal times. The record indicated that he met the criteria for release at 9:30 PM.

D: Post-Episode Debriefing (Debriefing):

According to the record, a RN conducted a Debriefing at 9:30 PM. Documentation indicated that the recipient was able to identify the stressors occurring prior to the restraint and to verbalize an understanding of the causes and consequences of his aggressive behaviors. He was also able to identify other methods to control the aggressive behavior, was encouraged to discuss his feelings related to the restraint episode and stated that he was aware that he could request that staff assist him prior to the escalation of his anxiety. The recipient informed the RN that he felt that staff could not have helped him to remain in control regarding this episode.

The RN determined that the recipient did not obtain a physical injury associated with the restraint and his physical well-being and privacy had been addressed. The reasons the early interventions were not successful were discussed with the recipient.

E: Restriction of Rights Notice (Notice):

According to documentation, the recipient was provided with a Notice for the 4 hour restraint episode that began at 5:30 PM and ended at 9:30 PM. The reason for the restriction was listed as the recipient was in seclusion, given emergency medication and he continued to escalate. He banged on the door and demanded to be placed in restraints. The record indicated that the Notice was delivered to the recipient and he did not wish to have anyone notified of the restriction.

Summary of Allegation 2 and Allegation 3

Documentation indicated that when the recipient was given medication in a pill form, he dropped the pill and stepped on it. When he was given another, he became angry and started, cursing, yelling, and threatening staff. He requested to be placed in seclusion in order to regain control and walked to the seclusion area without any type of physical hold. His aggressive behaviors continued after placement in seclusion and the administration of emergency

medication. The record indicated that he pounded on the door of the seclusion room and demanded to be placed in restraints. The recipient's records included the following: 1) a physician's order for the restraints/seclusion; 2)Restraint/Seclusion Flowsheets documenting monitoring during the restraint/seclusion episodes; 3) documented debriefing when the restraint/seclusion ended; and 4) a Restriction of Rights Notice provided to the recipient pertinent to the restraint/seclusion procedures. All of the records were in accordance with Code requirements

Conclusion to Allegation 2 and Allegation 3

Based on information obtained, the allegation that the recipient was placed in restraints and seclusion without a valid reason for their use is unsubstantiated. No recommendations are issued

Suggestion

When it is necessary to implement a restrictive procedure, facility staff should make certain that a recipient is asked if he wants the Notice sent to anyone and indicate the recipient's choice on the Notice.